AMENDED IN ASSEMBLY JUNE 26, 2014

AMENDED IN SENATE MAY 22, 2014

SENATE BILL No. 1276

Introduced by Senator Hernandez

February 21, 2014

An act to amend Sections 127400, 127405, 127420, 127425, 127450, 127454, and 127455 of the Health and Safety Code, relating to health care billing.

LEGISLATIVE COUNSEL'S DIGEST

SB 1276, as amended, Hernandez. Health care: fair billing policies.

(1) Existing law requires a hospital, as defined, to maintain an understandable written policy regarding discount payments for financially qualified patients as well as a written charity care policy, and authorizes a hospital to negotiate the terms of a payment plan with a patient. Existing law requires that uninsured patients or patients with high medical costs who are at or below 350% of the federal poverty level be eligible for charity care or a discount payment policy from a hospital, as specified, and requires that specified patients be eligible for discount payments to an emergency physician. Existing law defines a patient with high medical costs as a person whose family income does not exceed 350% of the federal poverty level and who does not receive a discounted rate from the hospital or physician as a result of his or her 3rd-party coverage.

This bill would instead require a hospital to negotiate with a patient regarding a payment plan, taking into consideration the patient's family income and essential living expenses. This bill would require the hospital to use a specified formula to create a reasonable payment plan, as defined, if the hospital and the patient cannot agree to a payment plan.

This bill would change the definition of a person with high medical costs to include those persons who do receive a discounted rate from the hospital as a result of 3rd-party coverage. This bill would also require an emergency physician or his or her assignee to use a specified formula to calculate a reasonable payment ~~plan~~ *formula* when ~~no agreement can be reached on the amount of payment between~~ a patient *is* attempting to qualify for eligibility under the emergency physician's discount payment policy. *This bill would authorize an emergency physician or his or her assignee to rely on the determination of family income and essential living expenses made by the hospital at which emergency care was provided for purposes of calculating the reasonable payment formula, and would authorize an emergency physician or his or her assignee, at his or her discretion, to accept self-attestation of family income and essential living expenses by a patient or a patient's legal representative.*

(2) Existing law requires a hospital or emergency physician to make a reasonable effort to obtain from the patient, or his or her representative, information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care, including private health insurance, and requires the hospital or emergency physician to provide a patient who has not shown proof of 3rd-party coverage with specified information, including a statement that he or she may be eligible for specified health coverage programs, including Medi-Cal and the California Children's Services program, and applications for those programs.

This bill would require the hospital or emergency physician to obtain information as to whether the patient may be eligible for the California Health Benefit Exchange and to include in the information provided to a patient that has not shown proof of 3rd-party coverage a statement that the consumer may be eligible for coverage through the California Health Benefit Exchange or other state- or county-funded health coverage programs. The bill would also specify that, when a patient applies, or has a pending application, for another health coverage program at the same time he or she applies for charity care or a discount payment program, that neither application precludes eligibility for the other program.

(3) Existing law requires a hospital or an emergency physician to have a written policy defining standards and practices for the collection of debt, and a written agreement from any agency that collects debt that it will adhere to the standards and practices.

This bill would require the affiliate, subsidiary, or external collection agency that is collecting hospital or emergency physician receivables to comply with the definition and application of a reasonable payment plan, as defined.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 127400 of the Health and Safety Code is amended to read:

127400. As used in this article, the following terms have the following meanings:

(a) "Allowance for financially qualified patient" means, with respect to services rendered to a financially qualified patient, an allowance that is applied after the hospital's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.

(b) "Federal poverty level" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

(c) "Financially qualified patient" means a patient who is both of the following:

(1) A patient who is a self-pay patient, as defined in subdivision (f), or a patient with high medical costs, as defined in subdivision (g).

(2) A patient who has a family income that does not exceed 350 percent of the federal poverty level.

(d) "Hospital" means a facility that is required to be licensed under subdivision (a), (b), or (f) of Section 1250, except a facility operated by the State Department of State Hospitals or the Department of Corrections and Rehabilitation.

(e) "Office" means the Office of Statewide Health Planning and Development.

(f) "Self-pay patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile

insurance, or other insurance as determined and documented by the hospital. Self-pay patients may include charity care patients.

(g) "A patient with high medical costs" means a person whose family income does not exceed 350 percent of the federal poverty level, as defined in subdivision (b). For these purposes, "high medical costs" means any of the following:

(1) Annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months.

(2) Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

(3) A lower level determined by the hospital in accordance with the hospital's charity care policy.

(h) "Patient's family" means the following:

(1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.

(2) For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

(i) "Reasonable payment plan" means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

SEC. 2. Section 127405 of the Health and Safety Code is amended to read:

127405. (a) (1) (A) Each hospital shall maintain an understandable written policy regarding discount payments for financially qualified patients as well as an understandable written charity care policy. Uninsured patients or patients with high medical costs who are at or below 350 percent of the federal

poverty level, as defined in subdivision (b) of Section 127400, shall be eligible to apply for participation under a hospital's charity care policy or discount payment policy. Notwithstanding any other provision of this article, a hospital may choose to grant eligibility for its discount payment policy or charity care policies to patients with incomes over 350 percent of the federal poverty level. Both the charity care policy and the discount payment policy shall state the process used by the hospital to determine whether a patient is eligible for charity care or discounted payment. In the event of a dispute, a patient may seek review from the business manager, chief financial officer, or other appropriate manager as designated in the charity care policy and the discount payment policy.

(B) The written policy regarding discount payments shall also include a statement that an emergency physician, as defined in Section 127450, who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level. This statement shall not be construed to impose any additional responsibilities upon the hospital.

(2) Rural hospitals, as defined in Section 124840, may establish eligibility levels for financial assistance and charity care at less than 350 percent of the federal poverty level as appropriate to maintain their financial and operational integrity.

(b) A hospital's discount payment policy shall clearly state eligibility criteria based upon income consistent with the application of the federal poverty level. The discount payment policy shall also include an extended payment plan to allow payment of the discounted price over time. The policy shall provide that the hospital and the patient shall negotiate the terms of the payment plan, and take into consideration the patient's family income and essential living expenses. If the hospital and the patient cannot agree on the payment plan, the hospital shall use the formula described in subdivision (i) of Section 127400 to create a reasonable payment plan.

(c) The charity care policy shall state clearly the eligibility criteria for charity care. In determining eligibility under its charity care policy, a hospital may consider income and monetary assets of the patient. For purposes of this determination, monetary assets shall not include retirement or deferred compensation plans

qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. Furthermore, the first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility.

(d) A hospital shall limit expected payment for services it provides to a patient at or below 350 percent of the federal poverty level, as defined in subdivision (b) of Section 127400, eligible under its discount payment policy to the amount of payment the hospital would expect, in good faith, to receive for providing services from Medicare, Medi-Cal, the Healthy Families Program, or another government-sponsored health program of health benefits in which the hospital participates, whichever is greater. If the hospital provides a service for which there is no established payment by Medicare or any other government-sponsored program of health benefits in which the hospital participates, the hospital shall establish an appropriate discounted payment.

(e) A patient, or patient's legal representative, who requests a discounted payment, charity care, or other assistance in meeting his or her financial obligation to the hospital shall make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. If the person requests charity care or a discounted payment and fails to provide information that is reasonable and necessary for the hospital to make a determination, the hospital may consider that failure in making its determination.

(1) For purposes of determining eligibility for discounted payment, documentation of income shall be limited to recent pay stubs or income tax returns.

(2) For purposes of determining eligibility for charity care, documentation of assets may include information on all monetary assets, but shall not include statements on retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. A hospital may require waivers or releases from the patient or the patient's family, authorizing the hospital to obtain account information from financial or commercial institutions, or other entities that hold or maintain the monetary assets, to verify their value.

(3) Information obtained pursuant to paragraph (1) or (2) shall not be used for collections activities. This paragraph does not prohibit the use of information obtained by the hospital, collection agency, or assignee independently of the eligibility process for charity care or discounted payment.

(4) Eligibility for discounted payments or charity care may be determined at any time the hospital is in receipt of information specified in paragraph (1) or (2), respectively.

SEC. 3. Section 127420 of the Health and Safety Code is amended to read:

127420. (a) Each hospital shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the hospital to a patient, including, but not limited to, any of the following:

(1) Private health insurance, including coverage offered through the California Health Benefit Exchange.

(2) Medicare.

(3) The Medi-Cal program, the Healthy Families Program, the California Children's Services program, or other state-funded programs designed to provide health coverage.

(b) If a hospital bills a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, as a part of that billing, the hospital shall provide the patient with a clear and conspicuous notice that includes all of the following:

(1) A statement of charges for services rendered by the hospital.

(2) A request that the patient inform the hospital if the patient has health insurance coverage, Medicare, Healthy Families Program, Medi-Cal, or other coverage.

(3) A statement that, if the consumer does not have health insurance coverage, the consumer may be eligible for Medicare, Healthy Families Program, Medi-Cal, coverage offered through the California Health Benefit Exchange, California Children's Services program, other state- or county-funded health coverage, or charity care.

(4) A statement indicating how patients may obtain applications for the Medi-Cal program and the Healthy Families Program, coverage offered through the California Health Benefit Exchange,

or other state- or county-funded health coverage programs and that the hospital will provide these applications. The hospital shall also provide patients with a referral to a local consumer assistance center housed at legal services offices. If the patient does not indicate coverage by a third-party payer specified in subdivision (a) or requests a discounted price or charity care, then the hospital shall provide an application for the Medi-Cal program, the Healthy Families Program, or other state- or county-funded health coverage programs. This application shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care.

(5) Information regarding the financially qualified patient and charity care application, including the following:

(A) A statement that indicates that if the patient lacks, or has inadequate, insurance, and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment or charity care.

(B) The name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital's discount payment and charity care policies, and how to apply for that assistance.

(C) If a patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for a hospital charity care or discount payment program, neither application shall preclude eligibility for the other program.

SEC. 4. Section 127425 of the Health and Safety Code is amended to read:

127425. (a) Each hospital shall have a written policy about when and under whose authority patient debt is advanced for collection, whether the collection activity is conducted by the hospital, an affiliate or subsidiary of the hospital, or by an external collection agency.

(b) Each hospital shall establish a written policy defining standards and practices for the collection of debt, and shall obtain a written agreement from any agency that collects hospital receivables that it will adhere to the hospital's standards and scope of practices. This agreement shall require the affiliate, subsidiary, or external collection agency of the hospital that collects the debt to comply with the hospital's definition and application of a reasonable payment plan, as defined in subdivision (i) of Section

127400. The policy shall not conflict with other applicable laws and shall not be construed to create a joint venture between the hospital and the external entity, or otherwise to allow hospital governance of an external entity that collects hospital receivables. In determining the amount of a debt a hospital may seek to recover from patients who are eligible under the hospital's charity care policy or discount payment policy, the hospital may consider only income and monetary assets as limited by Section 127405.

(c) At time of billing, each hospital shall provide a written summary consistent with Section 127410, which includes the same information concerning services and charges provided to all other patients who receive care at the hospital.

(d) For a patient that lacks coverage, or for a patient that provides information that he or she may be a patient with high medical costs, as defined in this article, a hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after initial billing.

(e) If a patient is attempting to qualify for eligibility under the hospital's charity care or discount payment policy and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the hospital shall not send the unpaid bill to any collection agency or other assignee, unless that entity has agreed to comply with this article.

(f) (1) The hospital or other assignee that is an affiliate or subsidiary of the hospital shall not, in dealing with patients eligible under the hospital's charity care or discount payment policies, use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills.

(2) A collection agency or other assignee that is not a subsidiary or affiliate of the hospital shall not, in dealing with any patient under the hospital's charity care or discount payment policies, use as a means of collecting unpaid hospital bills, any of the following:

(A) A wage garnishment, except by order of the court upon noticed motion, supported by a declaration filed by the movant identifying the basis for which it believes that the patient has the ability to make payments on the judgment under the wage

garnishment, which the court shall consider in light of the size of the judgment and additional information provided by the patient prior to, or at, the hearing concerning the patient's ability to pay, including information about probable future medical expenses based on the current condition of the patient and other obligations of the patient.

(B) Notice or conduct a sale of the patient's primary residence during the life of the patient or his or her spouse, or during the period a child of the patient is a minor, or a child of the patient who has attained the age of majority is unable to take care of himself or herself and resides in the dwelling as his or her primary residence. In the event a person protected by this paragraph owns more than one dwelling, the primary residence shall be the dwelling that is the patient's current homestead, as defined in Section 704.710 of the Code of Civil Procedure, or was the patient's homestead at the time of the death of a person other than the patient who is asserting the protections of this paragraph.

(3) This requirement does not preclude a hospital, collection agency, or other assignee from pursuing reimbursement and any enforcement remedy or remedies from third-party liability settlements, tortfeasors, or other legally responsible parties.

(g) Extended payment plans offered by a hospital to assist patients eligible under the hospital's charity care policy, discount payment policy, or any other policy adopted by the hospital for assisting low-income patients with no insurance or high medical costs in settling outstanding past due hospital bills, shall be interest free. The hospital extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments due during a 90-day period. Before declaring the hospital extended payment plan no longer operative, the hospital, collection agency, or assignee shall make a reasonable attempt to contact the patient by telephone and, to give notice in writing, that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. Prior to the hospital extended payment plan being declared inoperative, the hospital, collection agency, or assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. The hospital, collection agency, or assignee shall not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for

nonpayment prior to the time the extended payment plan is declared to be no longer operative. For purposes of this section, the notice and telephone call to the patient may be made to the last known telephone number and address of the patient.

(h) Nothing in this section shall be construed to diminish or eliminate any protections consumers have under existing federal and state debt collection laws, or any other consumer protections available under state or federal law. If the patient fails to make all consecutive payments for 90 days and fails to renegotiate a payment plan, this subdivision does not limit or alter the obligation of the patient to make payments on the obligation owing to the hospital pursuant to any contract or applicable statute from the date that the extended payment plan is declared no longer operative, as set forth in subdivision (g).

SEC. 5. Section 127450 of the Health and Safety Code is amended to read:

127450. As used in this article, the following terms have the following meanings:

(a) "Allowance for financially qualified patient" means, with respect to emergency care rendered to a financially qualified patient, an allowance that is applied after the emergency physician's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.

(b) "Emergency care" means emergency medical services and care, as defined in Section 1317.1, that is provided by an emergency physician in the emergency department of a hospital.

(c) "Emergency physician" means a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code who is credentialed by a hospital and either employed or contracted by the hospital to provide emergency medical services in the emergency department of the hospital, except that an "emergency physician" shall not include a physician specialist who is called into the emergency department of a hospital or who is on staff or has privileges at the hospital outside of the emergency department.

(d) "Federal poverty level" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

(e) "Financially qualified patient" means a patient who is both of the following:

(1) A patient who is a self-pay patient or a patient with high medical costs.

(2) A patient who has a family income that does not exceed 350 percent of the federal poverty level.

(f) "Hospital" means a facility that is required to be licensed under subdivision (a) of Section 1250, except a facility operated by the State Department of State Hospitals or the Department of Corrections and Rehabilitation.

(g) "Office" means the Office of Statewide Health Planning and Development.

(h) "Self-pay patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the emergency physician. Self-pay patients may include charity care patients.

(i) "A patient with high medical costs" means a person whose family income does not exceed 350 percent of the federal poverty level if that individual does not receive a discounted rate from the emergency physician as a result of his or her third-party coverage. For these purposes, "high medical costs" means any of the following:

(1) Annual out-of-pocket costs incurred by the individual at the hospital that provided emergency care that exceed 10 percent of the patient's family income in the prior 12 months.

(2) Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months. The emergency physician may waive the request for documentation.

(3) A lower level determined by the emergency physician in accordance with the emergency physician's discounted payment policy.

(j) "Patient's family" means the following:

(1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and

dependent children under 21 years of age, whether living at home or not.

(2) For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

(k) "Reasonable payment ~~plan~~" *formula"* means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means, for purposes of this subdivision, expenses for all of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

SEC. 6. Section 127454 of the Health and Safety Code is amended to read:

127454. (a) Each emergency physician shall make all reasonable efforts to obtain from the patient, or his or her representative, information about whether private or public health insurance or sponsorship may fully or partially cover the charges for emergency care rendered by the emergency physician to a patient, including, but not limited to, any of the following:

(1) Private health insurance, including coverage offered through the California Health Benefit Exchange.

(2) Medicare.

(3) The Medi-Cal program, the Healthy Families Program, the California Children's Services program, or other state- or county-funded programs designed to provide comprehensive health coverage.

(b) If the emergency physician or his or her representative bills a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, as a part of that billing, the emergency physician shall provide the patient with a clear and conspicuous notice that includes all of the following:

(1) A statement of charges for services rendered by the emergency physician.

(2) A request that the patient inform the emergency physician if the patient has health insurance coverage, Medicare, Healthy Families Program, Medi-Cal, or other coverage.

(3) A statement that if the consumer does not have health insurance coverage, the consumer may be eligible for Medicare, Healthy Families Program, Medi-Cal, coverage through the California Health Benefit Exchange, California Children's Services program, other state- or county-funded health coverage, or discounted payment care.

(4) Information regarding the financially qualified patient and discounted payment application, including the following:

(A) A statement that indicates that if the patient lacks, or has inadequate, insurance, and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment. That statement shall also provide patients with a referral to a local consumer assistance center housed at legal services offices.

(B) The name and telephone number of the emergency physician's employee or office from whom or which the patient may obtain information about the emergency physician's discount payment policy, and how to apply for that assistance.

(C) If a patient applies, or has a pending application for, another health coverage program at the same time that he or she applies for charity care or a discount payment program, neither application shall preclude eligibility for the other program.

(c) (1) In addition to the statement of the charges, if the emergency physician uses the following notice in any billing, that emergency physician shall be deemed to have complied with the notice requirements of this section: "If you are uninsured or have high medical costs, please contact ____ (name of person responsible for discount payment policy) at ____ (area code and ~~telephone~~ *phone* number) for information on discounts and programs for which you may be eligible, including the Medi-Cal program. If you have coverage, please tell us so that we may bill your plan."

(2) If the emergency physician or the assignee of the emergency physician lacks the capacity to provide the notice specified in paragraph (1), the emergency physician or his or her assignee shall be deemed to have complied with the notice requirements of this section if the information required under this section is provided upon request and if the following is printed on the bill in 14-point bold type: "If uninsured or high medical bill, call re: discount."

SEC. 7. Section 127455 of the Health and Safety Code is amended to read:

127455. (a) Each emergency physician shall have a written policy about when and under whose authority patient debt is advanced for collection.

(b) Each emergency physician shall establish a written policy defining standards and practices for the collection of debt, and shall obtain a written agreement from any agency that collects emergency physician receivables that it will adhere to the emergency physician's standards and scope of practice. This agreement shall require the affiliate, subsidiary, or external collection agency of the physician that collects the debt to comply with the physician's definition and application of a reasonable payment ~~plan~~ *formula*, as defined in subdivision (k) of Section 127450. The policy shall not conflict with other applicable laws and shall not be construed to create a joint venture between the emergency physician and the external entity, or otherwise to allow physician and surgeon governance of an external entity that collects physician and surgeon receivables. In determining the amount of a debt the emergency physician may seek to recover from patients who are eligible under the emergency physician's charity care policy or discount payment policy, the emergency physician may consider only income and monetary assets as limited by Section 127452.

(c) For a patient that lacks coverage, or for a patient that provides information that he or she may be a patient with high medical costs, the emergency physician, an assignee of the emergency physician, or other owner of the patient debt, including a collection agency, shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after initial billing.

(d) If a patient is attempting to qualify for eligibility under the emergency physician's discount payment policy and is attempting in good faith to settle an outstanding bill ~~and no agreement can be made on the amount of payment, the emergency physician or his or her assignee shall apply the reasonable payment plan formula in subdivision (k) of Section 127450, and~~ *with the physician and surgeon by negotiating an extended payment plan*, the emergency physician or his or her assignee, including a collection agency, shall not report adverse information to a consumer credit agency

or commence a civil ~~action unless that entity has agreed to comply with this article.~~ *action.*

(e) (1) The emergency physician or other assignee shall not, in dealing with patients eligible under the emergency physician's discount payment policies, use wage garnishments or liens on primary residences as a means of collecting unpaid emergency physician bills.

(2) A collection agency or other assignee shall not, in dealing with any patient under the emergency physician's discount payment policy, use as a means of collecting unpaid emergency physician bills, any of the following:

(A) A wage garnishment, except by order of the court upon noticed motion, supported by a declaration filed by the movant identifying the basis for its belief that the patient has the ability to make payments on the judgment under the wage garnishment, that the court shall consider in light of the size of the judgment and additional information provided by the patient prior to, or at, the hearing concerning the patient's ability to pay, including information about probable future medical expenses based on the current condition of the patient and other obligations of the patient.

(B) Notice or conduct a sale of the patient's primary residence during the life of the patient or his or her spouse, or during the period a child of the patient is a minor, or a child of the patient who has attained the age of majority is unable to take care of himself or herself and resides in the dwelling as his or her primary residence. In the event a person protected by this paragraph owns more than one dwelling, the primary residence shall be the dwelling that is the patient's current homestead, as defined in Section 704.710 of the Code of Civil Procedure, or was the patient's homestead at the time of the death of a person other than the patient who is asserting the protections of this paragraph.

(3) This requirement does not preclude the emergency physician, collection agency, or other assignee from pursuing reimbursement and any enforcement remedy or remedies from third-party liability settlements, tortfeasors, or other legally responsible parties.

(f) Extended payment plans offered by an emergency physician to assist patients eligible under the emergency physician's discount payment policy or any other policy adopted by the emergency physician for assisting low-income patients with no insurance or high medical costs in settling outstanding past due emergency

physician bills, shall be interest free. The emergency physician's extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments due during a 90-day period. Before declaring the emergency physician's extended payment plan no longer operative, the emergency physician, collection agency, or assignee shall make a reasonable attempt to contact the patient by telephone, if the telephone number is known, and to give notice in writing that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. Prior to the emergency physician's extended payment plan being declared inoperative, the emergency physician, collection agency, or assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. *If the patient wishes to renegotiate the terms of the defaulted extended payment plan but no agreement can be reached on the amount of the payment, the emergency physician or his or her assignee shall apply the reasonable payment formula in subdivision (k) of Section 127450 to determine a monthly payment amount for a subsequent extended payment plan. If the reasonable payment formula would result in a payment of less than ten dollars ($10) a month, the subsequent extended payment plan shall be ten dollars ($10) per month.* The emergency physician, collection agency, or assignee shall not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment prior to the time the extended payment plan is declared to be no longer operative. *If after having defaulted on an extended payment plan the patient has entered into another extended payment plan with payments in the amount of either the reasonable payment formula or ten dollars ($10) per month and the patient fails to make all consecutive payments due during a 90 day period, that extended payment plan is inoperative.* For purposes of this section, the notice and telephone call to the patient may be made to the last known telephone number and address of the patient.

(g) For purposes of determining the reasonable payment formula in subdivision (k) of Section 127450, the emergency physician or his or her assignee may rely on the determination of family income and essential living expenses made by the hospital at which emergency care was provided. The emergency physician or his or her assignee, at his or her discretion, may accept self-attestation

of family income and essential living expenses by a patient or a patient's legal representative.

~~(g)~~

(h) Nothing in this section shall be construed to diminish or eliminate any protections consumers have under existing federal and state debt collection laws, or any other consumer protections available under state or federal law. If the patient fails to make all consecutive payments for 90 days and fails to renegotiate a payment plan, this subdivision does not limit or alter the obligation of the patient to make payments on the obligation owing to the emergency physician pursuant to any contract or applicable statute from the date that the extended payment plan is declared no longer operative, as set forth in subdivision (f).

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